

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|---|--|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/15/2013 | |
| NAME OF PROVIDER OR SUPPLIER ROBERT E LEE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00121177, IN00125257 and IN00125487.</p> <p>Complaint IN00121177 Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00125257 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00125487 Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 13, 14 and 15, 2013</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Survey team: Cheryl Fielden RN</p> <p>Census Bed type: SNF/NF: 62 Residential: 16 Total: 78</p> <p>Census payor type: Medicare: 9 Medicaid: 40 Other: 29 Total: 78</p> <p>Sample: 14</p> <p>Robert E Lee was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00121177, IN00125257 and IN00125487.</p> | | | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/15/2013 |
| NAME OF PROVIDER OR SUPPLIER ROBERT E LEE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | Continued From page 1 Quality review 3/19/13 by Suzanne Williams, RN | F 000 | | | |